

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14177

Reg. Dist. No.

14187

1. PLACE OF DEATH a. COUNTY <u>Luzen Anne</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Smithville</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>San An</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sudlersville</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last <u>Harry Gaylor Anthony</u>				4. DATE OF DEATH Month Day Year <u>12 30 1958</u>											
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 16-1884</u>		9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>House Painter</u>				11. BIRTHPLACE (State or foreign country) <u>md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>us</u>			
13. FATHER'S NAME <u>Harry Anthony</u>						14. MOTHER'S MAIDEN NAME <u>Sarah Sylvester</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>218-20-8799</u>				17. INFORMANT Address <u>Mrs Beulah Anthony Sudlersville</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured Skull - broken leg</u> DUE TO (b) <u>812X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH <u>at once</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)															
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Motor vehicle and pedestrian</u>											
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>12/30/58</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>				20f. (City or town) <u>Sudlersville</u>		(County) <u>Q.A.</u>		(State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .															
ACTUAL SIGNATURE <u>W. Henry Fisher</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>						DATE SIGNED <u>12/30-58</u>			
EXAMINER'S NAME (Type)						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Jan. 3, 1958</u>				22b. DATE THEREOF				22c. NAME OF CEMETERY OR CREMATORY <u>Church Hill Cem.</u>				22d. LOCATION (City, town, or county) <u>Church Hill Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Pelton Milington Md.</u>						ADDRESS				24a. REC'D BY REGISTRAR DATE <u>JAN 5 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Krawitz</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH	
6. OCCUPATION		7. MARITAL STATUS		8. COLOR		9. RELIGION		10. EDUCATION	
11. PRESENT ADDRESS		12. DATE OF DEATH		13. TIME OF DEATH		14. PLACE OF DEATH		15. CAUSE OF DEATH	
16. MANNER OF DEATH		17. SIGNATURE OF MEDICAL EXAMINER		18. SIGNATURE OF WITNESS		19. SIGNATURE OF CLERK		20. SIGNATURE OF REGISTRAR	
21. SIGNATURE OF CORONER		22. SIGNATURE OF JURY		23. SIGNATURE OF JUDGE		24. SIGNATURE OF SHERIFF		25. SIGNATURE OF CONSTABLE	
26. SIGNATURE OF DEPUTY SHERIFF		27. SIGNATURE OF DEPUTY CONSTABLE		28. SIGNATURE OF DEPUTY CLERK		29. SIGNATURE OF DEPUTY REGISTRAR		30. SIGNATURE OF DEPUTY CORONER	
31. SIGNATURE OF DEPUTY JURY		32. SIGNATURE OF DEPUTY JUDGE		33. SIGNATURE OF DEPUTY SHERIFF		34. SIGNATURE OF DEPUTY CONSTABLE		35. SIGNATURE OF DEPUTY CLERK	
36. SIGNATURE OF DEPUTY REGISTRAR		37. SIGNATURE OF DEPUTY CORONER		38. SIGNATURE OF DEPUTY JURY		39. SIGNATURE OF DEPUTY JUDGE		40. SIGNATURE OF DEPUTY SHERIFF	
41. SIGNATURE OF DEPUTY CONSTABLE		42. SIGNATURE OF DEPUTY CLERK		43. SIGNATURE OF DEPUTY REGISTRAR		44. SIGNATURE OF DEPUTY CORONER		45. SIGNATURE OF DEPUTY JURY	
46. SIGNATURE OF DEPUTY JUDGE		47. SIGNATURE OF DEPUTY SHERIFF		48. SIGNATURE OF DEPUTY CONSTABLE		49. SIGNATURE OF DEPUTY CLERK		50. SIGNATURE OF DEPUTY REGISTRAR	
51. SIGNATURE OF DEPUTY CORONER		52. SIGNATURE OF DEPUTY JURY		53. SIGNATURE OF DEPUTY JUDGE		54. SIGNATURE OF DEPUTY SHERIFF		55. SIGNATURE OF DEPUTY CONSTABLE	
56. SIGNATURE OF DEPUTY CLERK		57. SIGNATURE OF DEPUTY REGISTRAR		58. SIGNATURE OF DEPUTY CORONER		59. SIGNATURE OF DEPUTY JURY		60. SIGNATURE OF DEPUTY JUDGE	
61. SIGNATURE OF DEPUTY SHERIFF		62. SIGNATURE OF DEPUTY CONSTABLE		63. SIGNATURE OF DEPUTY CLERK		64. SIGNATURE OF DEPUTY REGISTRAR		65. SIGNATURE OF DEPUTY CORONER	
66. SIGNATURE OF DEPUTY JURY		67. SIGNATURE OF DEPUTY JUDGE		68. SIGNATURE OF DEPUTY SHERIFF		69. SIGNATURE OF DEPUTY CONSTABLE		70. SIGNATURE OF DEPUTY CLERK	
71. SIGNATURE OF DEPUTY REGISTRAR		72. SIGNATURE OF DEPUTY CORONER		73. SIGNATURE OF DEPUTY JURY		74. SIGNATURE OF DEPUTY JUDGE		75. SIGNATURE OF DEPUTY SHERIFF	
76. SIGNATURE OF DEPUTY CONSTABLE		77. SIGNATURE OF DEPUTY CLERK		78. SIGNATURE OF DEPUTY REGISTRAR		79. SIGNATURE OF DEPUTY CORONER		80. SIGNATURE OF DEPUTY JURY	
81. SIGNATURE OF DEPUTY JUDGE		82. SIGNATURE OF DEPUTY SHERIFF		83. SIGNATURE OF DEPUTY CONSTABLE		84. SIGNATURE OF DEPUTY CLERK		85. SIGNATURE OF DEPUTY REGISTRAR	
86. SIGNATURE OF DEPUTY CORONER		87. SIGNATURE OF DEPUTY JURY		88. SIGNATURE OF DEPUTY JUDGE		89. SIGNATURE OF DEPUTY SHERIFF		90. SIGNATURE OF DEPUTY CONSTABLE	
91. SIGNATURE OF DEPUTY CLERK		92. SIGNATURE OF DEPUTY REGISTRAR		93. SIGNATURE OF DEPUTY CORONER		94. SIGNATURE OF DEPUTY JURY		95. SIGNATURE OF DEPUTY JUDGE	
96. SIGNATURE OF DEPUTY SHERIFF		97. SIGNATURE OF DEPUTY CONSTABLE		98. SIGNATURE OF DEPUTY CLERK		99. SIGNATURE OF DEPUTY REGISTRAR		100. SIGNATURE OF DEPUTY CORONER	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14188

CERTIFICATE OF DEATH

Reg. Dist. No.

14178

1. PLACE OF DEATH o. COUNTY <u>Queen Anne</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stevensville, Md</u>		c. LENGTH OF STAY IN 1b <u>2 1/2</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stevensville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Sellies</u> First Middle <u>Bailey</u> Last				4. DATE OF DEATH Month <u>12</u> Day <u>4</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1892</u>	9. AGE (In years last birthday) <u>66</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Waterman</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Bailey</u>				14. MOTHER'S MAIDEN NAME <u>Lena Nixon</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>WWI</u>		16. SOCIAL SECURITY NO. <u>2</u>		17. INFORMANT Address <u>Harrison Bailey, Stevensville, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>331X</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>3 d.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct.</u> , 19 <u>58</u> , to <u>Dec.</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Dec 2</u> , 19 <u>58</u> , and that death occurred at <u>6:30</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Irvin G. Hoyt</u> M.D.				ADDRESS (Street, city or town, state) <u>Queenstown, Md.</u> DATE SIGNED <u>12/8/58</u>			
PHYSICIAN'S NAME (Type) <u>Irvin G. Hoyt MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-8-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bathsrock Cam</u>		22d. LOCATION (City, town, or county) (State) <u>Stevensville Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Dabiel, Eastern, Md</u> ADDRESS				24a. REC'D BY REGISTRAR DATE <u>DEC 10 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton L. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14179

14189

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>QUEEN ANNE'S</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>PENNA.</u> b. COUNTY <u>LANCASTER.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL QUEENSTOWN</u>		c. LENGTH OF STAY IN 1b <u>30 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LANCASTER, PENNA 75 x 3</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>23 HAGER STR.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>IRENE</u> Middle <u>C.</u> Last <u>DEAN</u>				4. DATE OF DEATH Month <u>DEC</u> Day <u>24</u> Year <u>1958</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 4 1887</u>	9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>PENNA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Crumblin</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Wolf</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>DORIS A. HITCH, 521 MANOR Rd, GLEN BURNIE, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>Suddenly</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>W. Henry Fisher</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>W. HENRY FISHER</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>DEC. 27, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Conestoga Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>LANCASTER Co. PENNA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James H. Butler, Jr. of Butler Bros., Centerville, Maryland.</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 29 '58</u>		24b. REGISTRAR'S SIGNATURE <u>James H. Butler</u>	

14190 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millington</u> <u>Crumpton</u> adult life				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crumpton</u> <u>Millington, Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Pondtown</u> RFD				e. STREET ADDRESS <u>Pondtown</u> RFD		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Wm. Henry Elliott</u>				4. DATE OF DEATH Dec. 2, 1958 Month Day Year			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 15, 1881</u>	9. AGE (In years last birthday) yrs. <u>76</u>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>laborer</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles</u> <u>Unknown</u> <u>Elliott</u>				14. MOTHER'S MAIDEN NAME <u>Harriett Young</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>217-30-7590</u>		17. INFORMANT <u>Mary Lee</u> <u>Millington, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>422.1</u> DUE TO Arterio Sclerotic Vascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u> <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April</u> , 19 <u>58</u> at <u>Dec. 2</u> , 19 <u>58</u> that I last saw the deceased alive on <u>Dec. 2</u> , 19 <u>58</u> , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Robert W. Farr</u> M.D. <u>Chester</u>				PHYSICIAN'S NAME (Type) <u>Robert W. Farr, M. D.,</u> <u>Chestertown, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/6/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ewingtown Cem. Queen Anne Co. nr. Church Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Zenneth Walling</u>				ADDRESS <u>Chestertown, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 5 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kross</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK DEPARTMENT OF HEALTH BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH

<p>1. Name of deceased: _____</p>		<p>2. Sex: _____</p>	
<p>3. Date of birth: _____</p>		<p>4. Place of birth: _____</p>	
<p>5. Date of death: _____</p>		<p>6. Place of death: _____</p>	
<p>7. Cause of death: _____</p>		<p>8. Manner of death: _____</p>	
<p>9. Signature of attending physician: _____</p>		<p>10. Signature of registrar: _____</p>	
<p>11. Signature of medical examiner: _____</p>		<p>12. Signature of coroner: _____</p>	
<p>13. Signature of health officer: _____</p>		<p>14. Signature of county clerk: _____</p>	
<p>15. Signature of state health officer: _____</p>		<p>16. Signature of state registrar: _____</p>	
<p>17. Signature of state medical examiner: _____</p>		<p>18. Signature of state coroner: _____</p>	
<p>19. Signature of state health officer: _____</p>		<p>20. Signature of state registrar: _____</p>	
<p>21. Signature of state medical examiner: _____</p>		<p>22. Signature of state coroner: _____</p>	
<p>23. Signature of state health officer: _____</p>		<p>24. Signature of state registrar: _____</p>	
<p>25. Signature of state medical examiner: _____</p>		<p>26. Signature of state coroner: _____</p>	
<p>27. Signature of state health officer: _____</p>		<p>28. Signature of state registrar: _____</p>	
<p>29. Signature of state medical examiner: _____</p>		<p>30. Signature of state coroner: _____</p>	
<p>31. Signature of state health officer: _____</p>		<p>32. Signature of state registrar: _____</p>	
<p>33. Signature of state medical examiner: _____</p>		<p>34. Signature of state coroner: _____</p>	
<p>35. Signature of state health officer: _____</p>		<p>36. Signature of state registrar: _____</p>	
<p>37. Signature of state medical examiner: _____</p>		<p>38. Signature of state coroner: _____</p>	
<p>39. Signature of state health officer: _____</p>		<p>40. Signature of state registrar: _____</p>	
<p>41. Signature of state medical examiner: _____</p>		<p>42. Signature of state coroner: _____</p>	
<p>43. Signature of state health officer: _____</p>		<p>44. Signature of state registrar: _____</p>	
<p>45. Signature of state medical examiner: _____</p>		<p>46. Signature of state coroner: _____</p>	
<p>47. Signature of state health officer: _____</p>		<p>48. Signature of state registrar: _____</p>	
<p>49. Signature of state medical examiner: _____</p>		<p>50. Signature of state coroner: _____</p>	
<p>51. Signature of state health officer: _____</p>		<p>52. Signature of state registrar: _____</p>	
<p>53. Signature of state medical examiner: _____</p>		<p>54. Signature of state coroner: _____</p>	
<p>55. Signature of state health officer: _____</p>		<p>56. Signature of state registrar: _____</p>	
<p>57. Signature of state medical examiner: _____</p>		<p>58. Signature of state coroner: _____</p>	
<p>59. Signature of state health officer: _____</p>		<p>60. Signature of state registrar: _____</p>	
<p>61. Signature of state medical examiner: _____</p>		<p>62. Signature of state coroner: _____</p>	
<p>63. Signature of state health officer: _____</p>		<p>64. Signature of state registrar: _____</p>	
<p>65. Signature of state medical examiner: _____</p>		<p>66. Signature of state coroner: _____</p>	
<p>67. Signature of state health officer: _____</p>		<p>68. Signature of state registrar: _____</p>	
<p>69. Signature of state medical examiner: _____</p>		<p>70. Signature of state coroner: _____</p>	
<p>71. Signature of state health officer: _____</p>		<p>72. Signature of state registrar: _____</p>	
<p>73. Signature of state medical examiner: _____</p>		<p>74. Signature of state coroner: _____</p>	
<p>75. Signature of state health officer: _____</p>		<p>76. Signature of state registrar: _____</p>	
<p>77. Signature of state medical examiner: _____</p>		<p>78. Signature of state coroner: _____</p>	
<p>79. Signature of state health officer: _____</p>		<p>80. Signature of state registrar: _____</p>	
<p>81. Signature of state medical examiner: _____</p>		<p>82. Signature of state coroner: _____</p>	
<p>83. Signature of state health officer: _____</p>		<p>84. Signature of state registrar: _____</p>	
<p>85. Signature of state medical examiner: _____</p>		<p>86. Signature of state coroner: _____</p>	
<p>87. Signature of state health officer: _____</p>		<p>88. Signature of state registrar: _____</p>	
<p>89. Signature of state medical examiner: _____</p>		<p>90. Signature of state coroner: _____</p>	
<p>91. Signature of state health officer: _____</p>		<p>92. Signature of state registrar: _____</p>	
<p>93. Signature of state medical examiner: _____</p>		<p>94. Signature of state coroner: _____</p>	
<p>95. Signature of state health officer: _____</p>		<p>96. Signature of state registrar: _____</p>	
<p>97. Signature of state medical examiner: _____</p>		<p>98. Signature of state coroner: _____</p>	
<p>99. Signature of state health officer: _____</p>		<p>100. Signature of state registrar: _____</p>	

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

14191 CERTIFICATE OF DEATH

14181

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Green Anne</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Green Anne</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Centreville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Centreville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Route 3, Box 122</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>Gould</u> Last <u></u>				4. DATE OF DEATH Month <u>12</u> Day <u>15</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Col</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MARCH 8, 1885</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>tenant</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Benjamin Gould</u>				14. MOTHER'S MAIDEN NAME <u>MARY E GREEN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT Address <u>Thomas J. Gould Jr. Centreville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Thrombosis in left hemi-</u> DUE TO <u>plegia</u> (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>4 mo.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u></u> Day <u></u> Year <u>19</u> Hour o. m. <u></u> p. m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov.</u> , 19 <u>55</u> , to <u>Dec.</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Dec. 10</u> , 19 <u>58</u> , and that death occurred at <u>7:30</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Irvin G. Hoyt</u> M.D.				ADDRESS (Street, city or town, state) <u>Centreville, Md.</u> DATE SIGNED <u>12/18/58</u>			
PHYSICIAN'S NAME (Type) <u>Irvin G. Hoyt MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/18/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gould Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Centreville Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James S. DeKiehl, Easton, Md.</u> ADDRESS <u></u>				24a. REC'D BY REGISTRAR DATE <u>DEC 22 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton S. Kraus</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



14192 CERTIFICATE OF DEATH

Reg. Dist. No.

14182

1. PLACE OF DEATH a. COUNTY <u>Queen Anne's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chester</u>		c. LENGTH OF STAY IN 1b <u>all about</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>FRANK</u> First <u>HARRISON</u> Middle <u>LEE</u> Last		4. DATE OF DEATH Month <u>Dec</u> Day <u>22</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 27-1884</u>
9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Waterman</u>	
11. BIRTHPLACE (State or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Francis Lee</u>		14. MOTHER'S MAIDEN NAME <u>Rachael Ann Sperry</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-28-9836</u>	
17. INFORMANT <u>Marcella Lee</u>		Address <u>Chester Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary thrombosis</u> <u>420.1</u> DUE TO (b) <u>hypertensive cardio-vascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Arteriosclerosis general + cerebral</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Dec 22, 1958</u> <u>about 5 years</u> <u>about 5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>1st</u>		20f. (City or town) (County) (State) <u>St Stevensville</u> <u>Md</u>	
21. I certify that I attended the deceased from <u>May 10</u> , 19 <u>58</u> , to <u>Dec 22</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Dec. 22</u> , 19 <u>58</u> , and that death occurred at <u>5:04</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Theodor Sattelmaier</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>Stevensville</u> <u>Dec. 23, 1958</u>	
PHYSICIAN'S NAME (Type) <u>Theodor SATTELMAIER M.D.</u>		<u>STEVENSVILLE, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Dec 24-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Stevensville</u>	22d. LOCATION (City, town, or county) (State) <u>Stevensville Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edmund Barth</u>		ADDRESS <u>Barth Bros Centerville Md</u>	
24a. REC'D BY REGISTRAR DATE <u>DEC 29 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14193 CERTIFICATE OF DEATH

14184

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Queen Anne's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Centreville</u>				c. LENGTH OF STAY IN 1b <u>Most of life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ARCHIE G. REILLY</u>				4. DATE OF DEATH Month Day Year <u>Dec 17 1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Caucas</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 14 - 1897</u>	
9. AGE (In years last birthday) <u>61</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		11. BIRTHPLACE (State or foreign country) <u>Stevensville Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Philip Reilly</u>				14. MOTHER'S MAIDEN NAME <u>Rebecca Ralls</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>217-30-8026</u>			
17. INFORMANT <u>Ethel R Johnson daughter, Centreville Md</u>				Address <u>RFA.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>421.4</u> DUE TO <u>Chronic valvular disease of the heart</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerosis</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>June 1 1956</u> to <u>Dec 17 1958</u> that I last saw the deceased alive on <u>Dec 15 1958</u> , and that death occurred at <u>Centreville Md</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H. F. McPherson</u> M.D.				DATE SIGNED <u>12/19/58</u>			
PHYSICIAN'S NAME (Type) <u>H. F. McPherson</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec 20 - 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Burrowsville</u>		22d. LOCATION (City, town, or county) (State) <u>in Centreville Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Howard Baiter, Baiter Bros</u>				ADDRESS <u>Centreville Md</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 23 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Handwritten: William Henry Jones]</p>		<p>2. SEX [Handwritten: Male]</p>		<p>3. AGE [Handwritten: 65]</p>	
<p>4. DATE OF DEATH [Handwritten: May 15, 1958]</p>		<p>5. TIME OF DEATH [Handwritten: 10:30 AM]</p>		<p>6. PLACE OF DEATH [Handwritten: Home]</p>	
<p>7. CAUSE OF DEATH [Handwritten: Heart Disease]</p>		<p>8. MANNER OF DEATH [Handwritten: Natural]</p>		<p>9. PLACE OF BIRTH [Handwritten: Baltimore, Md.]</p>	
<p>10. OCCUPATION [Handwritten: Retired]</p>		<p>11. MARITAL STATUS [Handwritten: Married]</p>		<p>12. EDUCATION [Handwritten: High School]</p>	
<p>13. PREVIOUS ILLNESS [Handwritten: None]</p>		<p>14. MEDICAL HISTORY [Handwritten: None]</p>		<p>15. PHYSICIAN'S SIGNATURE [Handwritten: J. H. Smith]</p>	
<p>16. CORONER'S SIGNATURE [Handwritten: J. H. Smith]</p>		<p>17. COUNTY CLERK'S SIGNATURE [Handwritten: J. H. Smith]</p>		<p>18. DATE OF REGISTRATION [Handwritten: May 15, 1958]</p>	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14194 CERTIFICATE OF DEATH

Reg. Dist. No.

14185

1. PLACE OF DEATH a. COUNTY Queen Anne MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Kent.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sudlersville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St'll Pond 14X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Walraven Nursing Home		d. STREET ADDRESS 14X-2	
3. NAME OF DECEASED (Type or print) First CARRIE Middle SCHOFIELD Last SCHOFIELD		4. DATE OF DEATH Month December Day 5 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 22, 1881
9. AGE (In years last birthday) yrs. 77		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Still Pond, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John H. Harding		14. MOTHER'S MAIDEN NAME Caroline Scotten	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO. None	
17. INFORMANT Julian O. Scofield,		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Dehydration 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic myocarditis DUE TO (c) General Arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Unhygienic			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20	
20c. TIME OF INJURY Hour a. 7 p. m. Month, Day, Year 20		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug , 19 56 , to Dec 5 , 19 58 , that I last saw the deceased alive on Dec 4 , 19 58 , and that death occurred at 2 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE W. H. White		ADDRESS (Street, city or town, state) Sudlersville	
PHYSICIAN'S NAME (Type) W. H. White		DATE SIGNED 12/6/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 8, 1958	22c. NAME OF CEMETERY OR CREMATORY Georgetown Cem.	22d. LOCATION (City, town, or county) (State) Georgetown, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Edward F. Holloway, Millington, Md.		24. REC'D BY REGISTRAR DEC 10 58	
24b. REGISTRAR'S SIGNATURE Arthur S. Pears			

100

MEDICAL CERTIFICATION

VS A15 (4)
15M 9/55

